EXHIBIT 1620-1

CASE MANAGEMENT TIMEFRAMES

EXHIBIT 1620-1

CASE MANAGEMENT TIMEFRAMES

INITIAL CONTACT/VISIT	TIMEFRAME
Initial Contact (CM or designee)	Within 7 business days of enrollment
Initial on-site visit (non-Vent Dependent)	Within 12 business days of enrollment
Initial on-site (Vent Dependent)	Within 7 business days of enrollment
Initial service start-up (non-Vent Dependent)	Within 30 days of enrollment
Initial service start-up (Vent Dependent)	Within 12 business days of enrollment
CASE FILE UPDATES	**TIMEFRAME**
Initial CES	Prior to placement/services
Initial CES, when services in place at enrollment	Within 12 business days of enrollment
CES update	Prior to placement change to HCBS **and** at least once a year for all HCBS members, **and** when changes of services increases % to > 100%
CES when no discharge potential	No updates required, CES will reflect "NONE"
CATS ENTRIES	**TIMEFRAMES**
CES/CA160	Within 14 business days of date of action
Placement/CA161	Within 14 business days of date of action
Service Plan/CA165 (Tribal only)	Within 14 business days of date of action
REASSESSMENT VISITS	**TIMEFRAMES**
HCBS member	At least every 90 days
NF member	At least every 180 days
Ventilator Dependent members	At least every 90 or 180 days depending on placement as above (HCBS or NF)
Hospice members	At least every 90 days (every 90 or 180 days depending on placement beginning 10/2000)
Acute Care Only members – may be phone contact but on-site visit required at least once a year	▪ At least every 90 days for home based members ▪ At least every 180 days for institutionalized members*
DD members 12 years or older residing in a group home, unless the member is medically involved or seriously mentally ill/severely emotionally disabled (SMI/SED)	At least every 180 days*

*The "Next Review Date" on the CA161/Placement Maintenance screen in CATS will be calculated at 90 days for these members.

EXHIBIT 1620-2

ALTCS MEMBER CHANGE REPORT

EXHIBIT 1620-2

ALTCS MEMBER CHANGE REPORT

Date ___/___/___	ALTCS Program Contractor:	Reported By:	Phone #:

Member Name:	AHCCCS ID:	
Sent To: ❑ ALTCS Local Office ❑ DHCM ❑ Medical QC Supervisor	DOB:	Customer #:

Verification Attached? ❑ YES ❑ NO Verification Type: ❑ DE-130 ❑ Case Notes ❑ Other: _____

PART I - Demographic/Miscellaneous (Send DE-701 to ALTCS local office)

❑ **Address Change:**
- ❑ Residential
- ❑ Mailing
- ❑ Move to Home in Different Fiscal County
- ❑ Move Out of State

For: ❑ Representative ❑ Member

Effective Date: ___/___/___

❑ Name ❑ Sex ❑ DOB
❑ Phone # ❑ SSN ❑ DOD ❑ Other:

Explain Change:

PART II - Placement/Living Arrangement (Send DE-701 to ALTCS local office)

FROM: (previous residence) Enter facility name (if applicable), address and phone number. **TO:** (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, phone number. Enter comments.

FROM:		Phone: ( )	
Address:	City:	State:	Zip Code:

TO: Living Arrangement
- ❑ NF/ICF-MR
- ❑ Home
- ❑ Adult Foster Care Home *****
- ❑ Assisted Living Home *****
- ❑ Assisted Living Center *
- ❑ Assisted Living Center Room
- ❑ Alzheimer's Pilot Facility
- ❑ Level I or II Behavioral Health Center
- ❑ Level III Behavioral Health Center
- ❑ DD Group Home/Adult Development Home
- ❑ Child Developmental Foster Home/Large Group Setting
- ❑ Alternative Acute Living Arrangement
- ❑ Other _____

Effective Date: ___/___/___

Length of Stay:
- ❑ Permanent
- ❑ Temporary Until: ___/___/___
- ❑ Unknown

Facility Status:
- ❑ Medicare Certified
- ❑ Not Medicare Certified
- ❑ Licensed
- ❑ Unlicensed
- ❑ Contracted with PC
- ❑ Not Contracted with PC

Note to Local Office:

To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE.

***** If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.

Facility Name:	Provider ID:	Phone: ( )	
Address:	City:	State:	Zip Code:

Comments:

Member Name:	AHCCCS ID:

PART III - Client Status

Send the DE-701 to the ALTCS local office to report the following changes:		
❑ Member requests voluntary withdrawal from ALTCS (DE-130 attached) ❑ Change Contract Type from LTC to Acute for retroactive period (refusing services) ❑ Temporarily Absent from Arizona ❑ Returned to Arizona ❑ Tribal Enrollment Change – DHCM was contacted ❑ On-Reservation ❑ Off-Reservation	Date From: __/__/__	Comments:
Send the DE-701 to DHCM for the following changes:		
❑ From LTC to Acute– (Attach case notes) ❑ Services not available ❑ Temporarily out of service area ❑ Refusing Services (DE-130 not signed) ❑ From Acute to LTC ❑ Services are available ❑ No longer out of service area ❑ No longer Refusing Services	Date To: __/__/__	

PART IV - Change PC Within Maricopa County (Send DE-701 to ALTCS local office)

❑ Member Requests Enrollment Change to: _____(Program Contractor)

Reason:

❑ Erroneous Information/Error ❑ Family Continuity ❑ Lack of Choice ❑ Continuity of Placement

Comments:

PART V - Medicare/Other Health Insurance (Send DE-701 to ALTCS local office)

Medicare Part A ❑ YES ❑ NO Effective Date: __/__/__

Medicare Part B ❑ YES ❑ NO Effective Date: __/__/__ Disenrollment Date: __/__/__ Medicare Number: _____

Other Insurance ❑ YES ❑ NO Effective Date: __/__/__ Policy Number: _____

Insurance Carrier:

PART VI - Share of Cost (Send DE-701 to ALTCS local office)

❑ Reduce Share of Cost Due to Death of Member ❑ Other (Specify):	Effective: Month/Year __/__

PART VII - Income/Resource Change (Send DE-701 to ALTCS local office)

❑ Income ❑ Resources Explain the change:

Source or Type: _____

PART VIII - Ventilator Status Change/PAS Reassessment Request (See form instructions)

❑ Ventilator Dependent ❑ Non-Ventilator Dependent Effective date: _____

❑ PAS Reassessment Request – Check Reason for Assessment and provide comment

❑ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.

❑ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)

❑ Other (Explain):

Comments:

RESPONSE - (Completed by AHCCCS Employee)

❑ Refer to Part(s) _____

❑ Change Completed
Date Completed __/__/__
Effective Date __/__/__
❑ Member no longer eligible
Effective Date __/__/__

❑ Failed PAS
❑ Other Reason _____

❑ Member still eligible
❑ Passed PAS Reassessment
❑ DHCM has determined LTC status should continue

❑ Contract Type Change from _____ to _____
Begin date _____ End date _____
❑ SOC increased to $ _____ Effective Date: __/__/__
❑ SOC decreased to $ _____ Effective Date: __/__/__
❑ Income Changed
❑ Resources Changed

❑ Member eligible for acute care only
Effective Date __/__/__
❑ ALTCS Acute care
❑ Health Plan _____

❑ No Action Taken (see comments)

Comments:

Signature of AHCCCS Staff Person _____ Date Returned __/__/__

EXHIBIT 1620-2 (CONTINUED)
GUIDELINES ON WHEN TO USE A MEMBER CHANGE REPORT FORM

A Member Change Report (MCR) form should be sent to the local ALTCS eligibility office (except where noted) to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their ALTCS eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the contract or certification status of the facility where a member resides if the member chooses to remain in the facility.
- To report a change in the member's Ventilator Dependent status and request a PAS reassessment.
- To report a change in the member's DD status and request a PAS reassessment.
- To report he closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).
- To initiate a Contractor change when an E/PD member moves into another Contractor's service area in a HCB setting (does not include alternative residential settings.
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to an institutional setting and is expected to stay more than 90 days.
- To request Acute Care Only determination for a member who refuses ALTCS services but who has not signed a Voluntary Withdrawal. Also, change from Acute Care Only back to full LTC when the member accepts services. **MCRs for these situations must be sent to AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit.**
- To request a change in Contract Type when a member has received no LTC services for a full calendar months due to LTC service provider not available or member is temporarily out of the contractor's service area. **MCRs for these situations must be sent to DHCM/ALTCS Unit along with case notes.**
- To inform ALTCS when a member is temporarily out-of-state (>30 days).
- For Maricopa County E/PD members only – to report the member's request to change Program Contractors and the need for an enrollment choice.

NOTE – members who are temporarily out of the Contractor's service area may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor.

EXHIBIT 1620-3

UNIFORM ASSESSMENT TOOL
AND
GUIDELINES

AHCCCS/ALTCS UNIFORM ASSESSMENT TOOL – ACUITY DETERMINATIONS

MEMBER NAME: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

DETERMINED CLASS: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

DATE CLASS DETERMINED: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

Acuity determinations are based on this UAT matrix which describes characteristics of clients in each level. Information will be gathered through assessment of the client, interview with nursing facility staff, and medical record review, with particular attention to documentation regarding the past 30 days and updates within the MDS. *If the CM is uncertain regarding client's level of care, he/she will review case with their manager.*

	CLASS 1 **CLIENT HAS THREE OR MORE OF THE FOLLOWING**	**CLASS 2** **CLIENT HAS FOUR OR MORE OF THE FOLLOWING:**	**CLASS 3** **CLIENT HAS FIVE OR MORE OF THE FOLLOWING:**
BATHING, DRESSING, GROOMING	Independent or may participate in care, but requires assistance with bathing, dressing, and/or grooming.	Requires moderate assistance with bathing, dressing, and/or grooming.	Requires maximum assistance with bathing, dressing, and grooming.
FEEDING/ EATING	Independent or requires minimum set up/prompting assistance with feeding/eating.	Requires moderate assistance with feeding/eating.	Requires maximum assistance with feeding/eating (for example, tube feeding).
• **MOBILITY**	Independent or requires minimum or stand by assistance to move from one location to another with or without assistive devices.	Requires moderate assistance to move from one location to another with or without assistive devices.	Requires maximum assistance to move from one location to another with or without assistive devices.
• **TRANSFERRING**	Can transfer to some or all surfaces independently. Requires the assistance of no more than one person to transfer from one surface to another with or without assistive devices.	Requires hands-on physical guidance or assistance of one person for all transfers with or without assistive devices. The client may participate by being able to bear weight and pivot.	Requires assistance of 2 or more people to be physically lifted or moved from one surface to another with or without assistive devices.
BOWEL/ BLADDER	Continent or occasionally incontinent (*less than 7 times per week*) of bowel and/or bladder or may be continent at times with a training program.	Moderately (daily but some control) incontinent of bowel and/or bladder	Totally incontinent of bowel and/or bladder, receives scheduled toileting on a daily basis to avoid incontinence and/or receives care of a catheter or ostomy.
ORIENTATION/ BEHAVIOR	Requires no intervention or requires minimum staff intervention for episodes of confusion, memory deficits, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.	Requires moderate staff intervention. May have periodic emotional or mental disturbances, including combativeness.	Requires maximum staff intervention. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.
MEDICAL CONDITION	Stable, with no or some routine nursing/medical monitoring and care.	Conditions require more frequent monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).	Conditions require intense professional intervention to maintain stability (for example, unstable diabetes, come, terminal medical condition).
MEDICAL/ NURSING TREATMENTS	None or routine, such as range of motion and injections, as well as routine medication administration and routine catheter care. **ANYTHING MORE WOULD COUNT UNDER CLS 2**	Skilled nursing treatment in addition to routine medication administration. (Such as a treatment for skin condition.)	Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 decubitus, deep suctioning or an extensive rehab regime.

For ADLs: Minimum means some or less than half of the task, moderate means approximately one-half to less than three-quarters of the task, and maximum means extensive or approximately three-quarters of the task or more.

GUIDELINES FOR THE USE OF THE UNIFORM ASSESSMENT TOOL

I. PURPOSE

The purpose of the Uniform Assessment Tool (UAT) is to assess the acuity of Nursing Facility (NF) residents. The UAT will also be used on HCBS members when determining the NF rate to use when developing a Cost Effectiveness Study.

The use of the UAT is not intended to impact how Contractors determine authorizations for specialty levels of care (for example, wandering dementia and medical sub-acute).

II. DEFINITIONS

The following definitions apply for **most** situations. Exceptions are noted within this document and on the UAT.

- **Minimum** = means less than half the task.
- **Moderate** = means approximately 50% to less than 75% of the task.
- **Maximum** = means extensive or approximately 75% of the task or more.

III. ASSESSMENT CATEGORIES

The following information is for the purpose of assisting the case manager in completing the UAT. The information that follows is not intended to be all-inclusive. Case managers should consult with their supervisor/manager when a Characteristic does not clearly fall within a specific level.

The UAT is made up of eight (8) Characteristics:

A. Bathing/Dressing/Grooming
B. Feeding/Eating
C. Mobility
D. Transferring
E. Bowel/Bladder
F. Orientation/Behavior
G. Medical Condition
H. Medical/Nursing Treatment

Each Characteristic is assessed for one of three acuity levels. The cumulative levels determined for each Characteristic will determine the overall Class level for the member (Class 1, Class 2 or Class 3).

A single UAT form is designed to allow the case manager to document up to four (4) assessments. The case manager shall document the assessment-related date in the box associated with a Characteristic's determined acuity. When the eight (8) Characteristics are assessed, determine the Class level as summarized on the UAT. Finally, document, at the top of the tool, the review date, Class and the case manager's initials. The first assessment is documented in the upper left corner. Subsequent assessments would be documented in the upper right corner.

A. BATHING/DRESSING/GROOMING

Bathing - the process of washing, rinsing and toweling the body or body parts and transferring in/out of the tub or shower. This includes the ability to get the bath water and/or equipment, whether this is in bed, tub, shower, or sink. Use of assistive devices such as tub/shower chair, pedal/knee controlled faucets, or long-handled brushes does not disqualify the client from being independent. If the client has a problem getting to and from the bathroom to bathe, that should be reflected in the Mobility section and should not affect the score for bathing.

Assessment Considerations:

- When taking a bath/shower, can the person get their own towel, washcloth, soap, and run the water?
- Can the person tell if the water is too hot or too cold?
- Is the person able to get in and out of the shower or tub by themselves?
- Does the person need a bath bench, shower seat or hand held shower to assist with bathing?
- What kind of problems does the person have with bathing him/herself?

Minimum = the client requires up to minimal supervision, verbal cueing, assistance in and/or out of the shower, and may need assistance with washing back or lower extremities.

Moderate = the client requires step by step cueing with the entire bathing process, one person assist getting in and out of the tub/shower, and/or hands-on assistance with approximately 50% to 75% of the bathing process.

Maximum = the client is dependent on others for assistance with approximately 75% or more of the bathing process or requires assistance of two or more persons to get in and out of shower/tub or requires the use of a Hoyer lift.

Dressing - dressing includes laying out, putting on and fastening of clothing and footwear. Use of assistive devices such as reachers, sock pullers, shoe horns, Velcro fasteners does not disqualify the client from being independent.

Assessment Considerations:

- Can the person choose their own clothes, get them from the closet or drawer, put them on and button the buttons, fasten/close the zipper or tie their shoes?
- If someone lays out the clothes, can the person put them on?
- Does the person have assistive devices to assist in dressing, such as reachers, sock pullers, shoe horns, Velcro fasteners?
- How does the person get dressed if help is needed?

Minimum = the client may need some supervision or reminding (for example, laying out clothes, giving advice or being available.

Moderate = the client required hands-on physical assistance of another person or supervision with approximately 50% to 75% of the dressing activities.

Maximum = the client needs assistance with dressing approximately 75% or more of the time.

Grooming - grooming activities include combing hair, shaving, brushing teeth, washing hands/face, nail care and/or menses care. Obtaining the water and supplies necessary to complete the task are included in grooming.

Assessment Considerations:
- Can the person run the sink water and wash their face, comb their hair and brush their teeth?

Minimum = the client needs up to minimal supervision or reminding (for example, setting up grooming implements, giving advise, being available, menses care.

Moderate = the client requires some physical assistance or supervision or step by step cueing with approximately 50% to 75% of their grooming activities.

Maximum = the client is dependent on others for assistance with approximately 75% or more of their grooming activities.

B. EATING/FEEDING

Eating/Feeding – the process of getting nourishment by any means from a receptacle (dish, plate, cup, glass, bottle, etc.) into the body. Use of mechanical aids such as modified utensils or plate guards does not disqualify the client from being independent.

Assessment considerations:
- Can the person effectively get food and beverages into his/her mouth?
- Can the person cut his/her own meat?
- Does the person use any mechanical aids to assist with eating?
- Is the person receiving an intravenous or tube feeding as a means of total nutrition?
- Does the person need cueing or supervision to ensure an adequate intake?

Minimum = client requires some supervision, reminding, set-up or cutting, including alteration of food (for example, pureeing) or hands-on assistance with less than half of the meal task.

Moderate = client requires hands-on physical assistance, cueing or reminding with approximately 50% to 75% of the meal task, but can participate physically.

Maximum = client requires hands-on physical assistance with approximately 75% or more of the meal task or is totally dependent for nutritional needs (for example, tube feeding or TPN).

C. MOBILITY

Mobility – the extent of the client's purposeful movement within their residence. The use of assistive devices such as a wheelchair, walker or quad cane does not disqualify the person from being independent.

Assessment Considerations:
- Can the person purposely move about in his/her current environment independently?
- Does the person have an unstable gait or balance?
- Could the person avoid an obstacle in his/her path?
- Does the person use any assistive devices such as a cane, walker, wheelchair or handrails?
- Is the person unsafe without the assistance of another person in ambulating?

Minimum = approximately 50% or less of the time the client requires supervision, standby or hands-on assistance by one person for safety, including adjustment of assistive devices or restraints.

Moderate = approximately 50% to 75% of the time the client requires supervision, standby assistance or hands-on assistance of one person, including adjustment of assistive devices or restraints.

Maximum = approximately 75% or more of the time the client requires hands-on assistance of one or more persons or may be totally dependent on others for mobility (for example, cannot self-propel wheelchair).

D. TRANSFERRING

Transferring – the client's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc.

Assessment Considerations:
- Can the person move horizontally or vertically between the bed, chair, wheelchair or commode independently?
- Does the person display any weakness or unsteady balance, which would require assistance when transferring?
- Does the person use any mechanical devices such as a walker, cane, handrails or wheelchair to assist with transfers?
- Can the person physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver?

Minimum = can transfer to some or all surfaces independently. If needed, the assistance of no more than one person to transfer from one surface to another with or without assistive devices. The client may require some supervision or reminding or standby assistance for safety.

Moderate = the client requires hands-on physical guidance or assistance of one person for all transfers. The client may participate by being able to bear weight and pivot.

Maximum = the client requires assistance of 2 or more people to be physically lifted or moved.

E. BOWEL/BLADDER CONTINENCE

Continence – the ability to voluntarily control the discharge of body waste from bladder or bowel. Incontinence means the involuntary loss of bowel and bladder contents. Stress incontinence means the inability to prevent escape of small amounts of bowel/bladder contents during certain activities such as coughing, lifting or laughing.

Those who willfully toilet in inappropriate places will not necessarily be assessed as being incontinent. These behaviors may be assessed in other parts of this instrument (for example, Behaviors). Those who receive dialysis and do not urinate will be rated as continent of bladder.

Clients who have no voluntary control secondary to physiological conditions and rely upon dilatation, indwelling catheters, intermittent catheterization, ostomies, condom catheters or placed urinals for evacuation should be rated as totally incontinent in the applicable function.

Bladder Continence – the ability of the client to voluntarily control the discharge of body wastes from the bladder. A client with a Foley catheter or ostomy will be scored maximum.

Assessment Considerations:
- Does the person have any episodes of incontinence?
- Can the person "hold their urine" until they get to the toilet?
- Does the person have accidents when they sneeze or cough?
- How frequently does the person have accidents – once or twice a week, every day, once a month?

Minimum = the client may be incontinent less than 7 times a week.

Moderate = the client may be frequently incontinent or incontinent daily, but some control is present (for example, daytime, or if toileted frequently).

Maximum = the client is totally incontinent of bladder, receives scheduled toileting on daily basis to avoid bladder incontinence and/or receives care of a catheter or ostomy.

Bowel Continence - the ability of the client to voluntarily control the discharge of body wastes from the bowel. A client with an ostomy will be scored maximum.

Assessment Considerations:
- Does the person have bowel accidents?
- Does the person ever soil their clothing?
- How often does the person accidents?

Minimum = the client may be continent less than 7 times per week.

Moderate = the client may be frequently incontinent (7 times or more per week) or incontinent daily, but some control is present.

Maximum = the client has no voluntary control of bowel and/or receives care of an ostomy.

F. ORIENTATION/BEHAVIOR

Behavior – identify the presence of certain behaviors that may reflect the level of an individual's emotional functioning and need for intervention. Behaviors should be assessed based on the last 90 days (with particular attention to the past 30 days), or since the last review. Documentation should include frequency and type of behavior and if there has been or will be a request for mental health services.

Wandering is defined as moving about with no rational purpose and with a tendency to go beyond physical parameters of the environment in a manner that may jeopardize safety of self or others.

Repeated behaviors that cause injury to self (for example, biting scratching, picking behaviors; putting inappropriate objects into the ear, mouth or nose; head slapping or banging) or others (for example, physically attacking another person, throwing objects, punching, biting, pushing, pinching, pulling hair and physically threatening behavior).

Other repeated behaviors that interferes with the activities of others or the individuals own activities: for example, putting on or removing clothes inappropriately, stubbornness, sexual behavior inappropriate to time, place or person, excessive crying or screaming, persistent pestering or teasing; constantly demanding attention and urinating or defecating in inappropriate places, or threats and or attempts to take one's own life.

Minimum = requires staff intervention less than 50% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.

Moderate = requires staff intervention approximately 50% to 75% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May have periodic emotional or mental disturbances, including combativeness.

Maximum = requires staff intervention approximately 75% or more of the time. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.

G. MEDICAL CONDITION

Medical Condition – refers to the degree of stability of health care needs that may require nursing and/or medical monitoring of treatment(s) and/or therapy to restore and/or maintain function. This does not include maintenance regimens (monthly weights and blood pressure checks).

Minimum = stable, with routine nursing/medical monitoring and care.

Moderate = conditions require more frequent professional monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).

Maximum = conditions require intense professional intervention to maintain stability (for example, unstable diabetes, coma, terminal medical conditions).

H. MEDICAL/NURSING TREATMENTS

Medical/Nursing Treatments – refers to level of nursing and/or medical care that is required to perform medical assistance and interventions with current health care needs.

Minimum = Routine treatments, such as range of motion and injections, as well as routine medication administration and routine catheter care. Anything more would be considered at least "moderate".

Moderate = Skilled nursing treatment in addition to routine medication administration (for example, treatment of stage 1 to 3 pressure ulcer, tube feeding).

Maximum = Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 pressure ulcer, deep suctioning or an extensive rehab regimen.

EXHIBIT 1620-4

APPROPRIATE "D" PLACEMENT SCENARIOS
(ACUTE CARE ONLY)

EXHIBIT 1620-4

APPROPRIATE "D" PLACEMENT SCENARIOS

The following is a list of the common scenarios for which a member's placement is designated as Acute Care Only, "D" placement. This list is not all-inclusive.

- Member has refused both institutional and/or HCB services but does not want to withdraw from ALTCS.
- Member resides in a non-contracted setting and does not want to move.
- Member resides in an uncertified nursing facility.
- Member was determined eligible for acute care services under the ALTCS program due to financial reasons. Member will be enrolled with Contract Type designated as Acute Care Only.
- Member has received no LTC services for a full calendar month (for example, member receives services until June 12th when he leaves the state, receives no services at all in July, returns to the area and begins to receive services on August 20th. The member would be in a "D" placement for the month of July.)
- Member receives no LTC services for a full calendar month due to a lack of any available provider.
- Member receives no services, has signed a Voluntary Withdrawal and disenrollment is pending.

NOTE – members whose income is greater that 100% of the current Supplemental Security Income (SSI) amount who are in one of the above situations may not be eligible to remain enrolled in the ALTCS program. If the Contract Type of a member in one of those situations does not already indicate Acute Care Only, the case must be referred to AHCCCS (as described in Exhibit 1620-2) for an eligibility determination.

EXHIBIT 1620-5

ASSISTED LIVING CENTER/SINGLE OCCUPANCY FORM

ASSISTED LIVING CENTER/SINGLE OCCUPANCY

☐ Assisted Living Center

☐ Alzheimer's Pilot Facility

Member Name: _____ AHCCCS ID#: _____

Program Contractor: _____

I understand that, as an ALTCS member, I can choose to live by myself or have a roommate in an Assisted Living Center.

MY CHOICE FOR STAYING AT _____ IS (CHECK ONE CHOICE BELOW):
ASSISTED LIVING CENTER NAME

☐ Single Occupancy (one person per room)

☐ Shared Occupancy (at least 2 persons per room)

☐ Shared Occupancy until Single Occupancy becomes open

I understand that I may change my decision at any time and still remain at this facility.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Member

I hereby CHANGE my choice. My new choice is (check one choice below):

☐ Single Occupancy

☐ Shared Occupancy

☐ Shared Occupancy until Single Occupancy becomes open

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Member

cc: ALTCS Case Management File
Member/Representative
Assisted Living Center (original)

EXHIBIT 1620-6

HIGH COST BEHAVIORAL HEALTH REINSURANCE FORM

DIVISION OF HEALTH CARE MANAGEMENT
HIGH COST BH REINSURANCE REQUEST FORM

REQUEST/NOTIFICATION TYPE

Member Name: _____ AHCCCS #: _____

❑ Initial authorization **(NOT AVAILABLE AFTER 9/30/2007)**

❑ Renewal authorization

❑ Placement Change Effective Date: _____

Reason: _____

_____

❑ Termination Effective Date: _____

Reason: _____

❑ Other _____

_____

Signature: _____ Date: _____

Program Contractor Name: _____

MEMBER DEMOGRAPHIC INFORMATION

Member Name:	AHCCCS #:
Facility Name and Type:	DOB:
Placement Date:	Daily Rate:

DIAGNOSES

Include Psychiatric and Medical, as relevant

CURRENT BEHAVIORAL ISSUES

Describe member's current behaviors and the frequency and intensity of those behaviors; how behaviors impact ability to reside in facility with lower level of intervention

FACILITY PROGRAMMING DESCRIPTION

What is unique about this facility's program that enables it to manage/minimize the occurrence of behaviors the member has exhibited in the past and without which those behaviors would persist. *This information not required for renewal authorization requests if unchanged.*

BEHAVIORAL TREATMENT PLAN

Goals as well as both behavioral and chemical interventions in place to actively manage member's current behavioral issues.

Member Name:	AHCCCS #:

PLACEMENT HISTORY

Brief description of prior placement history, to include specific information regarding reason(s) placement(s) were unsuccessful. *This information not required for renewal authorization requests.*

RE-EVALUATION OF PLACEMENT

Results of periodic re-evaluation of the member's ability to function with a lower level of intervention than provided under current treatment plan (not just attempts at placement change). *This information not required for initial authorization requests.*

Signature: _____ Date: _____

Program Contractor Name: _____

EXHIBIT 1620-7

FFS OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM

EXHIBIT 1620-7
FFS OUT-OF-STATE NURSING FACILITY
PLACEMENT REQUEST FORM

SECTION A: TO BE COMPLETED BY THE CASE MANAGER

Member Name: _____ Tribal Contractor: _____

AHCCCS ID #: _____ Date of Birth: _____

Current Residence/Placement: _____

Diagnosis/Condition: _____

Location of/Distance to nearest family: _____

Level of involvement by family: _____

Names of AZ nursing facilities contacted for availability:

Indicate requested nursing facility:

☐ **San Juan Manor**
806 W. Maple
Farmington, NM 87401
AHCCCS ID: 562050

☐ **Four Corners Care Center**
818 North 400 West
Blanding, UT 84511
AHCCCS ID: 161406

☐ **Red Cliffs Regional**
1745 East 280 North
St. George, UT 84770
AHCCCS ID: 579039

☐ **St. George Care Center**
1032 East 100 South
St. George, UT 84770
AHCCCS ID: 449810

PCP Name: _____ AHCCCS Provider ID: _____

Case Manager: _____ Date: _____

SECTION B. TO BE COMPLETED BY AHCCCS

Comments: _____

Approved _____ Signature _____ Date _____
(Name and Title)

Denied _____ Signature _____ Date _____
(AHCCCS Medical Director or designee)

Init. Eff. Date 04/01/2004

EXHIBIT 1620-8

PROGRAM CONTRACTOR CHANGE REQUEST FORM

Exhibit 1620-8
Program Contractor Change Request

Member/Recipient's Name:	AHCCCS ID #:

I. CURRENT PROGRAM CONTRACTOR INFORMATION

Person Requesting Change:		Phone #:
Contractor Name:		
Fiscal County Name:	Fiscal County #:	Provider ID #:
Transfer: ❑ Approved ❑ Denied	Date:	

Reason: ❑ Member/Recipient Leaving Service Area ❑ Member/Recipient Resides Out of Service Area ❑ Within Service Area for Medical Continuity of Care ❑ Family Request ❑ Other – Specify:	Comments/Current Medical Condition: (Attach Medical Release, Current Plan of Care and Other Necessary Information)

Authorized Signature:	Title:	Date:

II. RECEIVING PROGRAM CONTRACTOR INFORMATION

Contractor Name:		
Fiscal County Name	Fiscal County Number:	Provider ID #:
Transfer: ❑ Approved ❑ Denied	Effective Enrollment Date:	

Authorized Signature	Title	Date

If approved, complete member/recipient information below and send this form to the AHCCCS Administration. If request denied, return form to originator.

III. MEMBER/RECIPIENT INFORMATION

Is this a change in Program Contractors within Maricopa County? ❑ YES ❑ NO

Is the change due to a move to a new county of fiscal responsibility? ❑ YES ❑ NO

Has the member/recipient physically moved to a new county of fiscal responsibility? ❑ YES ❑ NO
If YES, provide the new address below.

Effective Date of the Move:

Residential Address:	Facility Name (if applicable)			
Phone #:	Street	City	State	Zip
Mailing Address (if different):	Street	City	State	Zip

Type of Placement: ❑ Home & Community Based – Specify:
❑ Nursing Home ❑ Other – Specify:

IV. AHCCCS PROGRAM CONTRACTOR CHANGE REQUEST COORDINATOR USE ONLY

❑ Local Office Contacted:	NAME:	Date:	Initials:
❑ Local Office Changes Made:		Date:	Initials:
❑ MFIS Referral Completed		Date:	Initials:
❑ Enrollment Effective Date Adjusted in PMMIS		Date:	Initials:

Comments:

EXHIBIT 1620-9

ALTCS ENROLLMENT TRANSITION INFORMATION FORM (ETI)

ALTCS ENROLLMENT TRANSITION INFORMATION (ETI) FORM

Sending PC: _____ **Receiving PC:** _____

Transition Date: _____ **Rate Code:** _____

Member Name: _____ **DOB:** _____

AHCCCS ID: _____ **M or F (circle one)**

Primary Language Spoken: _____

Contact Person / Relationship:
indicate if Guardian, POA, etc _____

Contact Person Phone #: _____

PRIMARY HEALTH INSURANCE

Medicare #: _____ **Part A B D (circle all that apply)**

Medicare Advantage -PDP: _____ **SNP?** ☐ YES ☐ NO

PDP: _____ **Other:** _____

MEMBER LOCATION

Current Address: _____

Phone Number: _____

Facility Name (if applicable): _____

Type of Facility: ☐ **Skilled Nursing Facility** ☐ **Assisted Living Facility** ☐ **Behavioral Health**

Admission Date: _____ **Specialty Unit:** _____

Level of Care: _____ **ALF Room and Board Amount:** _____

MEDICAL INFORMATION

Diagnoses: _____

_____

PCP Name: _____ **PCP Phone** #: _____

Specialists (Including out of area)

Name: _____ **Type:** _____ **Phone #:** _____

Name: _____ **Type:** _____ **Phone #:** _____

Scheduled appointments/procedures: _____

_____

Special Medications/Treatments: _____

_____

CRS Services: _____

Pending Physicians orders not yet completed: _____

_____

Revised 10/01/2007, 12/01/2006

Member Name: _____

DIALYSIS

Site Name and Address: _____

Days: M T W Th F Sat Sun **Phone Number:** _____
Time: _____

Transportation Provided by: _____

Assistance and/or Type of Transportation Required: _____

_____

DME/SUPPLIES (see attached information for additional details on DME/Supplies as needed)

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Pending Issues requiring follow-up: _____

_____

PENDING GRIEVANCE? **Yes** **No** **Expected Resolution Date:** _____

What is nature of grievance? _____

HOSPITALIZED MEMBERS (complete if member is hospitalized on date form is completed)

Hospital: _____ **Phone:** _____

Admission Date: _____ **Admitting Diagnosis:** _____

Inpatient Treatments: _____

Expected Discharge Date: _____ **D/C To:** _____

OTHER/COMMENTS: _____

_____

_____

_____

Revised 10/01/2007, 12/01/2006

ALTCS ETI Form, Page Three

Member Name: _____

HCBS SERVICES (Check all that apply or attach Service Authorizations for details)

☐ **Adult Day Health**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Attendant Care**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Home Delivered Meals**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Homemaker**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Personal Care**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Respite**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Other** _____	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Emergency Alert**	**Provider**		**Phone#:**			

☐ **Home Health Nursing**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source: _____

☐ **Home Health Aide**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source _____

☐ **Hospice**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source: _____

Revised 10/01/2007, 12/01/2006

Member Name: _____

BEHAVIORAL HEALTH

BH Diagnosis: _____

BH Medications: _____

BH Services/Providers:

Service	Provider	Phone #	Frequency

# of Inpatient days remaining: _____ **Last Date of Judicial Review:** _____ **Outcome:** _____

☐ **COT** **Name on Court Order:** _____ **Expiration Date:** _____

REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:

- ☐ Last CM Assessment
- ☐ CM Summary
- ☐ Last Quarterly Behavioral Health Consult, if applicable
- ☐ Advanced Directives (Living wills, Powers of Attorney, etc), if applicable
- ☐ List of Medications
- ☐ EPSDT Forms, if applicable
- ☐ Contingency Plan, if member receiving critical services
- ☐ Guardian/Conservatorship or Power of Attorney, if applicable
- ☐ Current Year Remainder of ALTCS Adult Dental Benefit

  $_____

Case Manager Name: _____ **Phone:** _____ **Date:** _____

Revised 10/01/2007, 12/01/2006

EXHIBIT 1620-10

SAMPLE
IMPORTANT MEMBER RIGHTS NOTICE FORM

Janet Napolitano, Governor
Anthony D. Rodgers, Director

AHCCCS
Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

801 East Jefferson, Phoenix AZ 85034
PO Box 25520, Phoenix AZ 85002
phone ***602 417 4000***
www.ahcccs.state.az.us

[Must use Times New Roman and 14 point font, and be on AHCCCS letterhead]
AHCCCS Contractors may obtain an electronic copy of this form by contacting AHCCCS Division of Health Care Management.

IMPORTANT MEMBER RIGHTS NOTICE

As a result of the lawsuit *Ball v. Biedess*, the AHCCCS Administration is sending you this notice about your rights to receive "critical" long term care services at home when you are enrolled in the ALTCS Program.

You have the right to receive all the services in your care plan to help you with bathing, toileting, dressing, feeding, transferring to or from your bed and wheelchair and other similar daily activities. These services are called "critical services." Your program contractor or tribal contractor must make sure that you receive these critical services without delays. If there is a delay and you do not receive these services on time, your program contractor or tribal contractor must provide them within 2 hours of the time they are notified of the gap. (A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual's care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.) Your other long term care services cannot be reduced to make up for the critical services that you did not receive on time.

If you do not receive your critical services on time, call your provider to report the issue. In addition, you may also call your program contractor or tribal contractor at the telephone numbers listed below to report the problem. Your case manager will also provide you with phone numbers to call if there are delays in getting your critical services. You can also call your case manager or speak with an operator during normal business hours. Your program contractor or tribal contractor will also give you a form to fill out and mail back when there is a gap in critical services. You will get an answer by phone or in writing. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again.

AHCCCS will collect reports on gaps in critical services from each program contractor on a monthly basis. AHCCCS will also collect information to help determine how to set rates to pay workers who provide critical services. The program contractors will also give information to AHCCCS every 6 months about home care workers' current wages and benefits. This information will be made public once a year beginning August 15, 2005.

AHCCCS has hired experts to look at the amount of critical services available for AHCCCS members and the general population. This information will be available on October 15, 2005.

We will send you another Notice if a Court makes changes to this information. If you have any questions about this Notice, please call your program contractor or tribal contractor, your case manager or AHCCCS. Telephone numbers are listed below.

[CONTRACTOR INSERTS THEIR SPECIFIC CONTACT INFORMATION HERE]

Arizona Health Care Cost Containment System (AHCCCS)
(602) 417-4086 or 1 (800) 654-8713, extension 74086

Revised August 16, 2005

EXHIBIT 1620-11

SAMPLE
CRITICAL SERVICE GAP REPORT FORM

LOGO AND ADDRESS OF CONTRACTOR HERE

[Must use Times New Roman and 14 point font]

CRITICAL SERVICE GAP REPORT FORM

All ALTCS members have the right to receive all critical services in their care plan to help with bathing, dressing, toileting, feeding, transferring to or from your bed or wheelchair and other similar daily activities. If you do not receive your critical services as specified in your care plan, you should report this as quickly as possible. You should immediately call the service provider or our phone numbers listed on the Contingency Plan Form your case manager filled out with you. You may also call your case manager to help you receive these critical services.

In addition, you can mail this form to us at the address listed above telling us the services you have not received. As your program contractor, we will respond to you either by telephone or by the mail. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again. Please fill in the following:

Your Name:_____

AHCCCS ID Number (if available)_____

Date of Birth:_____

Date(s) you did not receive your services:_____

Critical Service(s) not received:_____

Comments:_____

_____

_____